FAMILY THERAPY IN THE POSTMODERN ERA

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Family therapy has entered the postmodern era, a period characterized by shifting values and an increasing respect for personal meaning. The primary theoretical and clinical developments that have accompanied this shift are discussed. Recent clinical trends, including the use of reflecting teams, self-disclosure, and postmodern supervision are examined. Finally, the feminist critique, health care reform, and marriage and family therapists' increasing collaboration with other mental health professionals are noted as key social forces currently influencing the field.

The purpose of this article is to chronicle the theoretical developments and clinical trends that have emerged in the profession of marriage and family therapy in recent years. These trends our historical period is marked by transition and new ways of seeing the world that the popular press has dubbed it the postmodern era. On the simplest level, the transition from the recent modern era to the postmodern era is marked by a flagging societal belief in one absolute, fixed reality for all people and an increasing acknowledgment that our culture embodies an infinite variety of equally valid ways to view the world (Anderson, 1990). Gone for increasing numbers of people are the fixed standards that have historically divided right from wrong, decent from indecent, noble from savage. Family values, for increasing numbers of people, are less rooted in sacred principles of church and community than in a very private mix of personal, situational beliefs.

The evolution of family therapy has been tremendously influenced by this postmodern environment in two ways. First of all, families are changing, partly due to the increased prevalence of divorce and remarriage during the last 20 years. Currently, over half of all marriages end in divorce, and projections show a full 67% of all recent first marriages may dissolve (Martin & Bumpass, 1989). Only half of all children living in the U.S. will reach 18 having lived continuously with both biological parents (Furstenberg, Nord, Peterson, & Zill, 1983). Family diversity is evident in other ways as well. Societal structures have eased regarding gay and lesbian families, cohabitating families, bi-racial families, and a host of other family definitions. American society's idea of family and what constitutes family is seemingly open to new interpretation, and family therapists must recognize multiple perspectives as a matter of course.

Secondly, over the last decade, theories explaining how reality is processed, or how we come to know what we know, have seized the imagination of family therapists and given the field a rich metaphorical context for working with families in the postmodern era. The most influential of these theories, second-order cybernetics, constructivism, and finally, social constructionism, have radically influenced the current practice of family therapy. We will briefly discuss these theories, their common respect for language as the medium of change, and then show how they are represented in four influential approaches to family therapy.

POSTMODERN THEORETICAL DEVELOPMENT

Second-Order Cybernetics

In the early to mid-1980s, family therapists began to strain against the basic cybernetic model (Weiner, 1948, 1961). It had informed work in the field since the 1960s. The original cybernetic model, sometimes referred to as the first cybernetics or first-order cybernetics, grew out of communication engineering and computer science and offered a coherent explanation of how systems of all kinds are regulated. Defined by Suzuki (1985) as "the science of patterns of organization" (p. 26), the cybernetic model was useful for family therapists as a way to conceptualize how families (as systems) maintain their organization. This was a technical paradigm, and families were assumed to follow a discernible and disruptible pattern of self-correction. The therapist, as an outside observer, could adjust through skillful and informed intervention.

During the 1980s, largely through the influence of Chilean biologist Humberto Maturana's work in the mechanics of perception, this traditional way of thinking about the role of the family therapist as a social-scientist engineer came into serious question. Maturana, writing with cognitive scientist Francisco Varela (1980) and other thinkers such as cybernetician Heinz von Foerster (1981), strongly challenged the idea of the objective observer. They postulated that we process information internally, and, therefore, reality as we know it is a construction of our own private and idiosyncratic way of organizing information rather than an accurate and universally true representation of what is out there. This philosophy of perception had important implications for family therapists. Maturana, in a 1985 interview with Richard Simon, states,

I am not saying that the different descriptions that the members of a family make are different views of the same system. I am saying that there is no one way which the system is; that there is no absolute, objective family. I am saying that for each member there is a different family, and that each of these is absolutely valid (p. 36).

Assimilating these ideas into the traditional cybernetic model was problematic. The therapist's status of informed but neutral observer, an expert entity outside of the family system, was challenged outright. This changing view gave rise to an expanded version of the original cybernetic model, which came to be known as second-order cybernetics; sometimes referred to as the new cybernetics or simply second cybernetics (Slovik & Griffith, 1992). Second-order cybernetics expanded the principles of first-order cybernetics to include the next level of order of communication patterns, examining the observer or therapist's role inside the treatment system itself. This shift focused the focus on patterns independent of the therapist to patterns that include the observer's role in constructing the reality being observed (von Foerster, 1981). The therapist is incorporated into the meaning system of the family and becomes an ac-

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tive contributor to a changing perspective along with everyone else in the family (Boscolo, Cecchin, Hoffman, & Penn, 1987). The power of the therapist's perspective then, is appreciated alongside the equally valid perspective of the rest of the system's experts

**Constructivism**

Second-order cybernetics represents a specific application of the general philosophy that came to be known as constructivism, a term popularized in part by cognitive psychologist Ernst von Glaserfeld (1984). Von Glaserfeld, in his theory of radical constructivism, pulled together the philosophical traditions from Kant to Piaget, strengthened by the scientific advances in cybernetic biology and cognition mentioned briefly earlier. He presented a model that proposed that reality is not discovered but constructed, invented by an individual in response to his or her world (Hoffman, 1985). Ultimate or preferred reality, for this way of thinking, is a highly personal matter.

Constructivism gained popularity in the world of social science, and particularly resonated with family therapists in need of a conceptual framework strong enough to lend stability to shifting values in a postmodern world. The term took on a life of its own, and was used in the most general sense by therapists who believed that people's personal beliefs about their lives and the meaning attached to those beliefs were the most important topics in the therapeutic conversation. The metaphor of *constructed reality* was a powerful one, inherent in this view is the idea that even the most troublesome personal realities (e.g., painful marital conflicts) are open to more viable personal reconstruction.

Lynn Hoffman (1985), perhaps the most avid chronicler during the mid-1980s of the constructivist application to the field of marriage and family therapy (she has since found the related paradigm of social constructionism to be more useful), places the values of constructivist thinking in an historical context and emphasizes how constructivism is leading the field away from an emphasis on behavior and toward a focus on personal meaning. She writes,

In family therapy, the emphasis has been on changing behaviors insofar as they are seen as part of a dysfunctional family system. The pendulum seems to be swinging the other way. Mental phenomena have been brought back from a long exile, and ideas, beliefs, attitudes, feelings, premises, values, and myths have been declared central again (pp 390).

**Social Constructionism**

There has been more than a little confusion surrounding the difference between constructivism and social constructionism. These terms have often been used interchangeably, especially in the late 1980s when both theories were simultaneously contributing to the general shift in systems thinking from therapist as primary mover to therapist as participant. The principal difference lies in theoretical origin, constructivism claims roots in biology and the physical properties of individual perception, whereas social constructionism is grounded in a philosophy of community. At its academic origin, constructivism is a scientific metaphor, pinpointing reality as a product of individually unique human processing. Social constructionism is anchored in a philosophy of community processing, it treats reality as a group project and actually questions the existence of an essential self apart from others. The tailored fit between social constructionism and family therapy has given rise to its current popularity in the field.

Largely popularized by social psychologist and philosopher Kenneth Gergen (1985), social constructionism shifts the focus on reality as a "social construction" product of the individual mind in reaction to the world (classic constructivism) to a product of our relationships with others (Hoffman, 1990). Gergen (1991) states,

> Are not all the fragments of identity the residues of relationships, and aren't we undergoing continuous transformation as we move from one relationship to another? Indeed, in postmodern times, the reality of the single individual, possessing his/her own values, emotions, reasoning capacities, intentions and the like, becomes implausible. (p. 28)

Although it is difficult for some to relinquish the idea of an autonomous, essential self, the social constructionist view offers an extremely useful platform for the work of family therapists. It allows the clinician a rich framework for conceptualizing and describing the power of community (family, peer group, ethnic group, world) to transform individual clients. The therapist participates in the social construction of new realities for clients, offering his or her perspective about a family to the pool of family and community perspectives, and believes each member of the system (including the therapist) will be changed by the power and relevance of this social exchange (Gergen, 1985).

**Language is the Medium**

The ideas of second-order cybernetics, constructivism, and social constructionism have all contributed to an approach to family therapy in recent years that is primarily language focused (Slovik & Griffith, 1992). This approach suggests that it is the meaning that people attach to their lives and how people express these meanings through language that facilitate client change. Therapy is aimed at, in Anderson's (1990) words, "the form-giving, meaning-making part, the narrator who at every waking moment of our lives spins out its account of who we are and what we are doing and why we are doing it" (p. 137).

Several theoretical approaches have arisen in this tradition that impact the field today. Each holds as the central tenet that the way clients talk or "language" about their problems will change their lives. Where these approaches differ is in their beliefs about the most helpful way to steer (or not to steer) the conversation. Below, we discuss the specific contribution each of these approaches has made to the postmodern fabric of family therapy.

**POSTMODERN THERAPEUTIC APPROACHES**

**Milan Group**

As the field began its move to a language-based, constructivist approach to family systems, the work of the Milan team (Selvini-Palazzoli, Boscolo, Cecchin, & Prata, 1978) presented a previously established set of ideas about therapy that fit well with these postmodern sensibilities. Ironically, the primary influence on the Milan group was their conscientious reading of Gregory Bateson (Hoffman, 1985). In 1980, they published a seminal paper called "Hypothesizing, Circularity, and Neutrality," which introduced the concept of *circular questioning* to the field (Selvini-Palazzoli, Boscolo, Cecchin, & Prata, 1980).

Circular questions were developed around the idea that families are built on patterns of relationship, and that often these relationship patterns are confused, hidden, or unacceptable to the family. These questions were designed to define and clarify these relationships, redefining Bateson's "news of a difference" to "news of a relationship difference" (Bos-
colo et al., 1987). In their book, *Milan Systemic Family Therapy*, Boscolo et al. (1987) divide circular questions into four different categories of inquiry: (a) questions about differences in the perception of relationships (Which of the children gets along best with their father? How would you describe the relationship between your mother and your father?); (b) questions about differences of degree (On a scale of one to ten, how bad do each of you want this relationship to work?); (c) now/then differences (Did the fighting start before or after her sister left for college?); and (d) hypothetical and future differences (How would things be different if it were still just the two of you? If the fighting stopped, who would benefit the most?) The authors state, in rather cybernetic language, "Such questions comprise a series of mutually causal feedback chains creating a complex and nonlinear picture of circularity" (p. 11). Put another way, circular questioning fills out the text of a family's story, uncovering themes of meaning that, although impactful, may have never been formally recognized.

Even though this questioning technique was originally used to aid in the forming of hypotheses and interventions, family therapists, including the Milan associates, began to recognize the therapeutic effect of these questions as a powerful intervention in themselves, squarely in line with the new ideas about the power of language to uncover and create new ways of looking at old problems (Penn, 1982, 1985; Tomm, 1987, a, 1987b). Circular questioning, with its ability to draw out relationship information important to families, is a popular technique for many family therapists today.

Another popular tool for family therapists, also the brainchild of the Milan associates, is the prescription of therapeutic rituals. Such rituals are often used when there are two different interpretations of a particular behavior within a family or when a family seems pulled in two different directions (e.g., when parental behavior is interpreted alternately as the expression of loving concern and as an authoritarian attempt to control). One possible therapeutic ritual for this specific example, known by some as odd/even days, is for the family to act according to the "loving concern" interpretation of parental behavior on odd days (Monday, Wednesday, Friday), and according to the "authoritarian control" interpretation on even days (Tuesday, Thursday, and Saturday). Sunday may be reserved for reacting spontaneously. The aim is to open the family up to the existence of different and equally viable interpretations of the same behavior, each carrying distinct implications. This exercise may help a family better recognize the existence of multiple meanings and loosen its hold on polarized adherence to the "truth" of a family problem (Neimeyer, 1993).

Another lasting influence of the Milan school is the idea of the therapeutic team. Although supervisors and trainees using a one-way mirror existed before, the Milan group was the first to formalize the idea of a therapeutic team, which consists of a therapist or therapists in the room with a family and therapeutic team members who join the treatment system from behind a one-way mirror. This idea has since expanded to the use of reflecting teams, which will be discussed later.

The primary contribution of the Milan school was a ready-made framework, linked to Bateson and firmly placed within the marriage and family field, for applying a language-based, collaborative way of thinking about and working with clients. The postmodern values inherent in the new second-order approaches fit well into this framework and, in a classically circular fashion, strongly influenced a modification of the original Milan thinking toward a less hierarchical, more collaborative model as the 1980s progressed (Cecchin, 1987).

**Collaborative Language Systems**

In 1986, Anderson, Goolishian, and Winderman of the Galveston Institute introduced the ideas of collaborative language theory and the problem determined system to the field. Here was a therapeutic ideal firmly rooted in social construction theory, fixed in its appreciation of the therapeutic conversation as the medium of change, and with strong ideas about what stance the therapist should take in that conversation. Collaborative language theory was the first of the postmodern theories to blatantly challenge the idea of the biological family as the targeted treatment system, proposing instead that a therapeutic system was a problem determined system that and anyone who had a significant stake in the problem belonged in the treatment system. The Galveston group, remaining faithful to constructionist philosophy, denied any notion of a problem as a static and definable construct shared by a family but maintained that a problem has as many descriptions and explanations as there are members of the system. The problem lies in the inability of these separate problem descriptions to find an audience with other members of the system. Anderson (1986) writes,

By the time a family reaches the therapist's office, . . . attentions and energies are focused on protecting one's own view. Under these circumstances, nothing shifts; no new meanings are generated. There is a break-down in conversation. (pp. 8-9)

Therapy, then, is an opportunity, not to eradicate the problem per se, but to help members in the system change their relationship to it through a dialogue that opens up new, less threatening interpretations. In collaborative language thinking, a problem is not solved through strategic intervention, but "dissolved" through "a natural consequence of dialogue" (Anderson, 1993; p. 324).

The collaborative language therapist's role, as explained in the writing of Anderson and Goolishian, is not terribly clear. They posit that the therapist, in order to fully facilitate a dialogical conversation among members of a system who have become monological, must take a "not-knowing" position (Anderson & Goolishian, 1992). A position of not-knowing does not imply that the therapist has no expertise, but it does imply that the therapist must leave all preconceived notions about clients and an ultimate standard of their health out of the therapy room (Atkinson & Heath, 1990). The therapist must expertly maintain an open and intensely curious stance regarding all of the possible meanings inherent in the problem system. The job is not to edit problematic stories or identify faulty narratives, but to elaborate the complaint (Kelly, 1955). Simply put, collaborative language theory asserts that problems are simply a result of each member of a problem system holding too tightly to one troublesome way of seeing a situation. The therapist is not interested in finding a solution to the problem, but rather in providing the ultimate facilitative conditions for clients to hear one another and to talk about a problem until it is no longer described as a problem (Loos, 1993). If the therapist is able to create a context, through intensely respectful inquiry and listening, in which "all participants can make room for the creativity and consciousness of each other" (Anderson & Goolishian, 1988, p 385), change will follow as a matter of dialogical course.

Although the ideas of the Galveston group have been criticized for their abstract nature (Nichols, 1989), they represent an important stance in a field characterized by specific and active strate-
gies of intervention. This way of thinking gives maximum respect to the power of largely unmanipulated conversation to promote active change. The Galveston message stresses the capacity of a respectful therapeutic stance to allow problem-determined systems to “dissolve” problems and find new meaning purely through the power of collaborative conversation (Anderson & Goolishian, 1988, 1990; Goolishian & Anderson, 1987, 1992a, 1992b).

Solution-Focused Therapy

Brief, solution-focused therapy (SFT) has increased in popularity in the last decade and is the therapy of choice for many family therapists today. Although commonly associated with the present managed-care health plans that require therapy to be brief, proponents of SFT do not accept an inferior, yet practical status. They believe that their methods are as effective as longer and more traditional approaches to working with clients (de Shazer et al., 1986, Kiser, 1988). The principles of SFT have been spread largely through the work of the Brief Systems Group, led primarily by de Shazer and Berg (de Shazer et al., 1986).

Like the Milan concept of circular questioning, the solution-focused approach capitalizes on Bateson’s “news of a difference.” Therapists using this approach ask clients to define their complaint or problem and then search for instances when this complaint is less present in their lives. Periods when clients are more liberated from their problem then become the focus of therapy, with an emphasis on the client’s beliefs and actions during these periods and how these ways of being might occur more frequently. Using a simple example, de Shazer et al. (1986) offer the case example of a client who defined his depression as a way of feeling that was markedly different than his occasional “up” days. The therapist then fully explored a typical up day for the client, paying close attention to the behavior and perceptions that would not normally occur on “down” days. The client was then asked to predict whether the next day would be an up or a down day; if he predicted a down day he was to get up the next morning and do something he would normally do on an up day. Not surprisingly, predictions of down days decreased in frequency over time, and the actual number of down days decreased significantly by the third session.

Several aspects of solution-focused work converge with the primary tenets of constructivist therapy. Therapists focus client attention on the client’s construction of solutions (e.g., depression is battled by the quest for client-derived elements of an up day). One of the most well-known SFT techniques, used to conceptualize and construct solutions, is the miracle question. Clients are asked some version of the following question: “If there were a miracle one night while you were sleeping and the problem was gone when you woke up, how would you know?” The client then may be asked how other members of his or her family or friends would know, and how he or she may act differently once the problem had miraculously disappeared (de Shazer, 1988). Solution-focused therapists expect that clients can successfully construct and apply solutions without focusing on the problem. Imagining the detailed effect of the miracle, in other words, can create the miracle itself. De Shazer (1988) states:

Solutions to problems are frequently missed because they often look like mere preliminaries; we end searching for explanations believing that without explanation a solution is irrational, not recognizing that the solution itself is its own best explanation. (p. 10)

Because of its highly directive nature, solution-focused therapy is often associated with the more strategic, therapist-as-expert models of family therapy. However, we argue that SFT fits well in the present postmodern environment because of its emphasis on and belief in helping clients construct solutions that best fit their own lives (de Shazer, 1991). Unlike earlier work in family therapy that assumed an ideal family arrangement and sought to change the structure or intergenerational boundaries towards the perceived ideal, SFT utilizes therapist direction to help clients create and live within their own brand of solution. The belief is in the power of creative vision to escape a problem focus rather than in the power of the therapist’s vision of a better way.

Narrative Therapy

Recently dubbed the “third wave” (after the pathology-focused and problem-focused waves; O’Hanlon, 1994), narrative approaches to family therapy are rooted in the idea that human lives are inherently narrative in form, reality is defined by the stories people live and the stories people tell (Neimeyer, 1993). Narrative therapists literally find (and help create) the stories that family members tell each other and themselves about who they are, and then enter these stories, hoping to influence the telling in ways that positively affect the family. In their 1990 book, Narrative Means To Therapeutic Ends, White and Epston posit that families and individuals often become bogged down in dominant narratives that disqualify, belittle, or constrain them. Narrative therapists attempt to enter the clients’ narrative world and offer an alternate or modified biography of their lives. Although any therapeutic approach that attempts to work with the stories people have about themselves is a narrative approach, White’s method of “externalizing” problems and Epston’s work with therapeutic letters are two techniques that are practically synonymous with the narrative therapy label.

White (White & Epston, 1990) has developed a way of interviewing clients that invites them to see the problems in their lives as separate from themselves. He does this by a process he calls relative influence questioning. In this form of questioning, White asks family members to give two different descriptions of the problem they are presenting for therapy. One is a description of the problem as it relates to their lives and the life of the family, and the other is a description of how the family members relate to and influence the life of the problem. In this way, the problem is externalized and objectified as an influence outside the life of the family members and is subject to their influence and control.

For example, a family who presents a troubled relationship between two warring pre-adult children may begin to talk about the role “hated” is playing in the relationship between the children and in the life of their family. Once the problem of hatred is externalized, the family can begin to create alternate stories about this emotional climate that were not possible in their previous descriptions of the problem. Through the use of unique outcome questions, the family may be encouraged to explore the conditions in which hatred thrives and the times when the children are able to defeat hatred. Now the family stories the entire family, brothers included, against the externalized problem, rather than the problem attaching itself to the character and worth of the brothers themselves. This metaphorical distance from the problem frees family members to see one another and their situation in a new, less threatening way, enabling them to modify their family story (and therefore, behavior) in ways that were not possible from a problem-saturated point of view.

Written narratives of clients’ lives are also powerful therapeutic tools used in this approach. White and Epston
(1990) regularly share their progress notes with clients to communicate their construction of how clients refuse to empower the problems they face. Epstein (Epston, 1994; White & Epstein, 1990) writes his case notes in the form of actual letters to clients (which he mails to them), creating comprehensive "re-tellings" of clients' stories held together by themes such as courage, endurance, or deep, abiding determination. These letters include direct quotes from the clients, taken as notes during each session, so that Epstein can use their own words to chronicle the prevailing themes in their lives. Often the written word, in its official commitment to time and space, carries a power for clients not found in the therapeutic conversation. Clients are able to read letters again and again, and the meaning of the narrative may actually change for them, marking their progress over time. In Epstein's (1994) words, "Letters ought to be moving experiences, doorways through which everyone can enter the family's story and be touched by the bravery, the pain and even the humor of the narrative" (p. 63).

The four postmodern approaches to family therapy mentioned here have had a tremendous impact on the field. Each contributes a unique and valuable piece of the current conversation, and many family therapists borrow ideas from each of these approaches in their work with clients. Next, we will discuss the place for the more established, first-order approaches to family therapy and how they are faring in the present postmodern environment.

THE OLD BECOMES NEW

As mentioned earlier, much of the work done and touted by family therapists prior to the last decade was conceptualized according to a traditional first-order cybernetic framework that featured overt therapeutic strategies designed to change families through technically precise interventions (Fisch, Weakland, & Segal, 1982, Haley, 1963, 1973, Minuchin, 1974). Perhaps the leading spokesman for the strategic approach to therapy during this time was Jay Haley (1973), who described strategic therapy as "not a particular approach or theory but a name for those types of therapy where the therapist takes responsibility for directly influencing people" (p. 17). This definition of strategic therapy, which we will adopt in this discussion, covers a host of approaches, including structural family therapy, which proceed on the premise that problems arise from a failure to achieve adequate accommodation to a norm (Simon, 1992, p. 381).

The strategic purist brings specific beliefs about family problems into therapy, and intervenes accordingly, with or without the family's conscious cooperation in the process. From a classically strategic point of view, including family members in a discussion of the therapeutic process may educate and fortify the resistance to change inherent in a stubborn family system that seeks stability over health. To include them would be like discussing one's strategy with an opponent before the actual game.

Strategic therapy has been successfully implemented by many family therapists and rightfully heralded as an approach that can facilitate change in families (Duncan, Parks, & Rask, 1990a, 1990b). For example, Minuchin's work with anorectics and their families was a dramatic example of the power of a pragmatic, theory-driven use of very direct intervention (Minuchin, Rosman, & Baker, 1978). However, in the last decade there has been a surge of negative opinion regarding strategic work with families, mostly in protest against the implicit power, control, and even manipulativeness associated with this approach (Held, 1992). The postmodern argument is that strategic therapy is largely built on fixed ideas about optimum family organization and health, and that covert therapeutic tactics built on such assumptions are an imposition of the therapist's reality on families whose ways of being are inherently unique and deserving of more respect.

The backlash against the postmodern critique from the pragmatic, strategic-friendly camp has been challenging and well-articulated (Golann, 1988, Held, 1992, Simon, 1992). Most writers fully acknowledge the contribution of second-order thinking, but rebel against the idea that strategy, assumption, or even some degree of therapist power can be separated from the therapeutic process. They argue that one need not abandon interventive strategy to honor second-order principles like respect for clients and the therapist's place within the system. They suggest that all forms of therapy must account for first-order elements, even those closely adhering to the prevailing second-order aesthetic. Golann (1988) has argued that, for many postmodern therapists, strategy has simply gone underground. He states: Power obscured eventually emerges—a therapeutic wolf clad as a second-order sheep (p. 56). Unconscious persuasion may be said to be ethically more objectionable than excessive and explicit strategic intervention because it is potentially dishonest and because it creates an even greater power hierarchy in favor of the therapist. (p. 63).

Golann also suggests that it was not the assumption of an objective reality or ideas about optimum family health (assumptions he believes are very difficult for anyone, postmodern or not, to eliminate from his or her consciousness) that were responsible for first-order abuses of power and influence in the past. He claims the problem lay in the belief that change was, and for some family therapists still is, "thought to be a higher value than respect, tact, and truth" (p. 56). Of course, those firmly in the second-order camp would argue that theoretical assumption is an issue and that power and influence are more likely to be abused in a field that endorses a certain informed and objective pre-eminence for the therapist.

Despite these fine points of theoretical tension, proposals for an integration of first and second-order thinking have been well-received (Atkinson & Heath, 1990; Simon, 1992, 1995). The middle ground seems to be that strategic tactics are appropriate when informed by second-order principles that openly acknowledge these strategies as ideas that may or may not be helpful. Their use ultimately depends on the family's willingness or desire to try them. It is not the therapist's job to slip these inherently useful interventions into the lives of change resistant families, but rather to bring these first-order ideas into the conversation with families and openly discuss their potential usefulness. Hoffman (1995), in a recent address, described how she may introduce strategies as blatantly manipulative as the paradoxical injunction to work with her clients. She simply explains the idea to them, including the rationale for the technique, and asks if they would like to try it. Speaking further on the postmodern integration of strategic ideas, Hoffman (1995) states:

I do not reject the more instrumental approaches in the family therapy field. Even though the stance I take may seem non-directive, there is nothing in it that says I should not give people concrete tasks and interpretations as long as I make it clear that I am only giving the "idea of" a task or interpretation (pp. 153-154).

This debate over first- and second-order approaches to therapy epitomizes the movement in the field over the last
decade. Family therapists have relaxed the belief that the original ideas of the field concerning family functioning and change hold the secrets to marital and family health, but most still respect the usefulness of these ideas when they can be integrated into the meaning systems of clients themselves. Family therapy has moved from an instrumental to a collaborative enterprise, our faith in the pragmatism of therapy is contingent on the aesthetic priority of our clients’ full participation in the ritual of change. The next section describes some clinical implications of this shift.

POSTMODERN DEVELOPMENTS

Reflecting Teams

The reflecting team, originally heralded by Andersen (1987) and his colleagues, is an increasingly popular tool, primarily used in family therapy training programs. With this approach, the one-way mirror becomes a two-way mirror, observing members of the therapeutic team share their thoughts and feelings directly with the clients rather than remaining invisible and relaying their input through the primary therapist. The effect is highly respectful, and squarely in line with second-order notions of a collaborative and non-hierarchical environment.

There are several ways to conduct reflecting teams. In Andersen’s description, after a period of time (ranging from 10 minutes to 45 minutes and occurring one or more times during the interview), the therapists dim the lights in the therapy room, which reverses the direction of the one-way mirror and reveals the therapeutic team on the other side. The family members and therapist then become the observers of the team as they converse among themselves about the family’s session. Comments made by the team members are not pre-planned, but spontaneously offered for possible further elaboration. Usually there are rules that guide the discussion; team members offer their comments as speculative and steer clear of criticism or ideas for intervention. The idea is not to offer directives to the family, but to give family members a wide array of personal reflections so that they can pick and choose any perspectives that may be helpful.

There have been many variations on the reflecting team since its initial introduction. Sometimes the reflecting team comes into the therapy room with the clients to carry on their conversation; sometimes the reflecting team is in the room the entire session, sitting off to one side until it is time for them to comment to one another, sometimes the family goes into the booth behind the mirror and the reflecting team comes into the therapy room so that the family has the opportunity to view the reflecting team from the exact vantage point of the professional observer. In terms of conversational rules, some reflecting teams have found it effective to include perspectives that may respectfully challenge family members (Sprenkle & Bischof, 1994).

At the conclusion of the reflections, the team re-enters behind the mirror and the interview continues with the family member’s reactions. Reflecting teams often are highly impactful, offering families a multitude of new perspectives from outside the established therapist-client relationship, underscoring the present work and/or opening the therapy up to new possible directions.

Increased Therapist Self-Disclosure

Because of the decreased emphasis on hierarchy and first-order boundaries between therapist and client, more family therapists are choosing to share stories from their own lives when they feel they are relevant and appropriate to the therapeutic conversation (Garfield, 1987). Although this is nothing new to more experiential approaches such as those established by Whitaker (1988) and Satir (1964), present second-order sensibilities have influenced even traditional family therapists toward a greater transparency.

Therapists who recognize that their own bias and/or emotional reaction to clients’ stories often stem directly from stories of their own may openly share parts of these stories in an effort to clarify the personal roots of their position. When the “expert hat” is removed, self-disclosure may also become a way of normalizing client struggles. Many family problems are more common than clients realize, and clients are frequently empowered by hearing about their therapists’ own struggles in these areas. Of course, there are still many different positions regarding the appropriateness and timing of self-disclosure and how these potentially powerful messages to clients should be managed.

Self of the Therapist

Because second-order family therapists are a part of the system within which they work, there has been an increased interest in therapists’ awareness of the interpersonal issues they bring into their work. Aponte (1992, 1994; Aponte & Winter, 1987), has been particularly effective in his efforts to bring “person of the therapist” issues to the forefront of family therapy training and supervision. Aponte has developed a person/practice model (Aponte & Winter, 1987) of training that directly addresses the need for increased therapist self-knowledge. Aponte (1994) states that the goals of the model are to lead trainees in:

(a) identifying and interpreting themes in their histories and current relationships; (b) accessing emotionally their own personal struggles, past and present; (c) articulating . . . how they have succeeded and failed with their personal and family issues, and (d) making explicit for themselves personal values, philosophy, and social factors (p 4).

Of course, this list could just as easily be a depiction of many therapists’ goals for their clients. There has been some concern over the therapeutic nature of this training focus and the potential dual relationships that may arise when supervisors/trainers facilitate the personal issues of those they serve. Aponte answers that self-of-the-therapist work is certainly therapeutic, but not therapy, because the goal of the trainer/supervisor is not to work through or resolve therapists’ issues but to improve their performance as therapists by helping them to more fully recognize these issues (Aponte, 1994). Therefore, therapists are strongly encouraged to seek their own personal therapy as an adjunct to self-of-the-therapist work. However, Aponte recognizes the complexity of this arrangement and admits that the boundary lines in such training are far from clear.

Therapists’ greater awareness of personal issues, however, is not simply a training issue. This awareness is an increasing expectation in the field for all therapists who are bringing themselves into client systems and influencing these systems in the tradition of the therapists’ own interpersonal histories.

Postmodern Supervision

Conducting supervision in the postmodern era is particularly challenging. The very term supervisor suggests a hierarchy of perspective not consistent with the postmodern assertion that age, experience, or conferred title do not lend greater validity to individual human perception. At the same time, supervisors are often responsible for training neophyte therapists, and feel an imperative to help them provide the best possible service for their clients. In order to walk the line between nonher-
archival, collaborative supervision and a model of supervision that imparts expert knowledge to supervisees, many postmodern supervisors attempt to practice first-order supervision with a second-order mind. That is, they openly share their thoughts, feelings, and interpretations with therapists but remain aware that these are their personal ideas about the therapeutic process. They rarely insist that therapists give these impressions credence over their own expertise in the therapy room. Rather, they attempt to create a supervisory atmosphere that encourages collaboration between supervisor and therapist, rather than therapist conformity to supervisor-imposed norms.

Hoffman (Chang & Mills, 1995) describes a "midwifery" model of supervision, where supervisors join with therapists in the actual therapy sessions and work alongside the supervisees with their clients (Anderson & Goolishian, 1991). During these therapy sessions, the supervisor, or "visiting therapist," also acts as a consultant, talking directly to the therapist about his or her own private reactions and beliefs concerning the course of therapy. This exercise allows the therapist to learn in a live collaborative setting and allows the supervisee a chance to experience more fully the world of the supervisee on a particular case.

Another indirect mode of postmodern supervision is for supervisors to take a case of their own, allowing their supervisees to form the therapeutic team and follow the case. In this set-up, the supervisor/therapist may take mid-session breaks and consult with supervisees for feedback, and post-sessions provide an opportunity for the supervisor/therapist to field questions about his or her work. Besides providing a wealth of information and modeling for the trainee, this reversal of positions demystifies the supervision process. It allows the supervisees to see the presumption that supervisors do super therapy far beyond the supervisee's level of capability as a myth that can hinder a free exchange of ideas in the supervision process.

This dedication to examining social imbalance and gender issues has opened up a similar dialogue in the field around issues for men in therapy (Farrell, 1993; Napier, 1991; Pittman, 1991). Family therapists are becoming more aware of men's struggles, including the traditional pressure to provide monetary support for their families, often at the expense of their own personal development and a depth of relationship with members of their families.

Health Care Reform

Health care reform has been a dark cloud on the horizon for the last few years, and many marriage and family therapists have already felt the nation's tightening hold on third party reimbursement for their services. Our country is slowly moving into a managed health care system, mainly due to a need to contain skyrocketing health care costs. The primary effect on family therapists is simple: Many will have to adjust to the values and priorities of the larger governing body that will, in essence, manage therapy.

According to Patterson and Scherger (1995), the goal of managed care will be primary care, which means a primary care physician will be responsible for the general health of a particular population and will act as case manager for that population. In this scenario, family therapists will be part of a multidisciplinary team managed by this primary physician. Marital or family therapy will not be covered as an end in itself, but the primary physician encountering depression or psychosomatic discomfort related to family problems may prescribe marital therapy as part of the treatment plan. Fee per hour service will give way to a capitated system where a set amount of dollars are allocated for patient services, and therapists have to manage treatment within the bounds of these available resources. Specific, measurable outcomes will be extremely important in this system, which is not particularly good news in an industry with few established links between specific technique and consistent, measurable outcome. On the bright side, patient satisfaction will also be very important, so the success or failure of therapy will not be determined solely by objective measurement.

Some would say that it is deeply ironic that we should be moving into a period of increased demands for specific, measurable psychological knowledge at the same time we are embracing a postmodern philosophy that openly questions the existence of such generalizable knowledge. It remains to be seen how the postmodern sensibility will fare.

**MAJOR SOCIAL INFLUENCES: THE FINAL POSTMODERN INGREDIENTS**

**The Feminist Critique**

The feminist critique of family therapy has posed a very real and necessary re-evaluation of some traditional ideas in the field. In many ways, the change in therapeutic perspective suggested by the feminist critique mirrors the influence of postmodernism on family therapy. Goldner (1991) writes that the feminist "preoccupation with and critique of power, secrecy, hierarchy, control, and expertise produced a commitment towards creating alternative, participatory, democratic forms of therapy." (pp. 120-121). Goldner also cites the influence of feminism on respect for process as a therapeutic end in itself, and argues that feminists have been major contributors to the popular postmodern idea of **conversation over intervention**.

In other ways, the feminist critique has been welded with a political fervor and insistence that is seemingly incompatible with the postmodern denunciation of absolute truth. The power politics of marriage, family structure, and therapy itself have been vigorously challenged as unfair to women, and many feminist family therapists have suggested that therapists are socially responsible to address these imbalances of privilege and power (Atkins, 1986; Bograd, 1992, Hare-Mustin, 1987). The feminist movement has challenged family therapists to "hold the line" concerning family violence and insist that families take direct and concrete action to stop the violence (through anger management groups or groups for male batters) before therapy continues (Bograd, 1986). Therapists who disagree with these positions have been subjected to moral and professional repute.

Addressing this issue, Goldner (1991) asserts that the postmodern tradition is potentially paralyzing for both feminist and traditional strategic therapists because it questions the absolute truth of each theory. As mentioned earlier in the discussion of applying first-order principles with a second-order sensibility, the postmodern movement does not preclude the passion of therapeutic assertion, but only the belief that one's assertions are fundamentally true for someone else (Atkinson & Heath, 1990). Recognizing this restriction, it could be argued that the feminist critique has taken the postmodern theory of social constructionism to new levels, critically examining our nation's social construction of gender roles and asking therapists to use their voice in the therapeutic conversation to challenge the roles they feel are unhealthy for families. Sprengle and Bischof (1994) point out that feminism "is one of the few movements within family therapy that has critically examined the values of the society to which family therapists are helping people adjust" (p. 13).
puzzle that may be relevant to their work with clients.

CONCLUSION

We have discussed the theoretical developments and broader clinical trends that have characterized the transition of family therapy into the postmodern era. The last few years have been extremely rich in theoretical development, with movement from an instrumental, technically rich tradition toward a greater appreciation for personal meaning and the solution of that meaning through language. Family therapists have weathered this transition well, working hard to integrate valuable traditional perspectives within a new collaborative, constructionist paradigm that is better suited to the shifting value systems of the present world.

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